Evidence of Insurability Statement
Life Coverage
Aetna Life Insurance Company

Read this instruction page carefully. Do NOT mail your completed statement to Metro. Make a copy for your records and send the original to Aetna. Aetna may contact you directly to request additional information upon receipt of this completed statement.

Instructions

Employee

Read the Privacy Notice and Misrepre-sentation section on "Page 2 of 4" of the Insurability Statement before completing.

Please Print

Complete the following items in Section A:

- Item A2 – Your Social Security Number
- Item A6 – Employee Date of Hire
- Item A7 – Employee Telephone Numbers
- Item A8 – Life Coverage Applied For (a, b and c)
- Item A9 – Reason for Requested Change and Annual Metro Earnings

Complete Section B. ***Be sure that*:**

- All items are completed.
- Only the names of individuals requesting coverage at this time are listed (B1). Check appropriate boxes regarding dependent child coverage, if applicable (B1a and B1b).
  - Height and Weight ***must*** be provided or this form will be returned unprocessed for your completion (B1).
- Complete dates and details are given for all "No" answers to questions B1a and B1b and for all "Yes" answers to questions in B2, Statement of Health (B3).
- The form is signed by you. If you are requesting spouse coverage, the spouse's signature is also required. Read the Certification, Acknowledgment and Authorization prior to signing the form (bottom of Section B).

Make a copy for your records. Mail the **original** to:

Aetna Life Insurance Company
Consumer Services
151 Farmington Avenue
Hartford, CT 06156-7318

1-800-523-5065

If a final underwriting decision cannot be made within six months, Aetna reserves the right to request a new Evidence of Insurability Statement.

Please Note: If this form is not completed in its entirety *and* signed, it will be returned unprocessed completion.

Privacy Notice

In evaluating your insurability, we (Aetna) will rely primarily on the health information you furnish to us in this Evidence of Insurability Statement. In addition, however, we may ask you to take a physical examination, or request additional medical information about you from any of the sources specified in the authorization on Page 4 of 4 of this form.

Disclosure of Information to Others

All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. For example, Aetna Life Insurance Company may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may apply for coverage, or to whom a claim for benefits may be submitted. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

Your Right of Access & Correction

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding), and to request correction, amendment or deletion of recorded personal information in states which provide such rights and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your (attending) physician. If you wish to exercise this right, or if you wish to have a more detailed explanation of our information practices, please contact:

Aetna Life Insurance Company
Medical Underwriting Department
151 Farmington Avenue
Hartford, CT 06156-2975

Under New Mexico law, a resident of New Mexico has the right to register as a "protected person" in connection with disclosure of confidential domestic abuse information. If you wish to exercise this right, write to the address shown above.

Misrepresentation

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison, and substantial civil penalties. Many other states have similar laws.

Attention Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

Attention Florida and Virginia Residents: Any person who knowingly and with intent to defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention DC Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

A. Plan Sponsor/Employer: Complete this Section - Please print.

1. Control Number	Suffix	Account	2. Employee Social Security Number
879372	11	011	- -

3. Plan Sponsor/Employer Name & Address	4. Employee Name & Address
ATTN: **Metropolitan Government of Nashville & Davidson County**	
Street	Street
City State ZIP Code	City State ZIP Code

5. Plan Sponsor - Authorized Rep. Telephone Number	6. Employee Date of Hire (MM-DD-YY)	7. Employee Telephone Numbers
( ) -		Work ( ) - Home ( ) -

8. **Life Coverage Applied for:** ☐ Employee ☐ Spouse ☐ Dependent

	Employee Supplemental Life (Employee Paid)	Spouse Life (Employee Paid)	Dependents Life (Employee Paid)
a. **Current** Amount of Life Insurance Coverage?	$_____	$_____	$_____
b. **Additional** Amount of Life Insurance Coverage requested?	$_____	$_____	$_____
c. Resulting **Total** Life Insurance Amount if Approved (a + b)?	$_____	$_____	$_____

9. Reason for Requested Coverage.

☐ Salary Increase ☐ Change in Multiple ☐ Late Applicant ☐ Change in Coverage Amount ☐ Life Event/Status Change

☐ Other (Please explain) _____

Employee's Annual Earnings: $ _____

B. Employee: Complete this Section - Please print.

1. Only the Names of Individual(s) Requesting Coverage at this Time Should be Listed

Name	Relationship	Birthdate *(MM/DD/YYYY)*	Birthplace (City, State)	Sex	Height (ft., in.)	Weight (lbs.)
Employee:	Self					
Spouse:						
Dependent(s):						

Complete these questions if dependent children are listed above. ***Give dates and details for "No" answers using the space provided in Number 3.***

	Yes	No	
a.	☐	☐	Do all dependent children live in your household and depend solely on you for support?
b.	☐	☐	If any dependent child is age 19 or older, is/are they regularly attending school?

2. Statement of Health for Individual(s) Listed Above. ***Give complete dates and details for "Yes" answers using the space provided in Number 3.***

	Yes	No	
a.	☐	☐	Has any individual been hospitalized within the past two years or is any individual currently scheduled or recommended for an inpatient or outpatient surgical/diagnostic procedure? If yes, list individual(s) and details as to type of procedure in Number 3.
b.	☐	☐	Is any individual currently taking medication(s) for any condition? If yes, list individual(s), diagnosis, medication & dosage, and indicate duration of use in Number 3.
c.	☐	☐	Does any individual use tobacco products (includes cigarettes, cigar, pipe and chewing tobacco)? If yes, list individual(s) and product(s) used in Number 3.

B. Employee: Complete this Section (Continued) - Please print.

2. Statement of Health - Continued. *Give complete dates and details for "Yes" answers using the space provided in Number 3.*

Within the past 10 years have you (or your spouse or dependents) consulted a physician, received medical treatment for or been diagnosed with any of the following illnesses or conditions? ***(If "Yes" is checked, circle all that apply.)***

	Yes	No	
d.	☐	☐	Chest pain, high blood pressure, stroke, disease of the heart, circulatory system or blood disorder?
e.	☐	☐	Cancer, tumor, lupus, rheumatoid arthritis, AIDS, HIV* related disorders or any other immune system deficiency disorder?
f.	☐	☐	Respiratory: bronchitis, asthma, emphysema, any other lung disorder/disease?
g.	☐	☐	Diabetes, kidney disease, disorder of the pancreas, liver, intestines or stomach?
h.	☐	☐	Nervous system: epilepsy, paralysis, progressive/chronic neuromuscular diseases, substance abuse (alcohol/drugs) or mental illness?

*AIDS (Acquired Immune Deficiency Syndrome) is a serious disease. It is caused by a virus called HIV (Human Immuno-deficiency Virus). The virus is found in some human body fluids of infected people, most notably in semen and blood. If the AIDS virus finds its way into the bloodstream, it can damage the body's defenses against disease, resulting in life-threatening diseases. There is no known cure.

3. Use this space to provide the details for **"No" answers in Number 1** and **"Yes" answers in Number 2**. Be specific as to individual(s) affected.

Ques. No.	Individual Affected	Diagnosis	Date of Onset	Details/ Symptoms	Treatment(s) Received	Full Recovery Date

☐ *Check here if you are providing additional information on a separate attachment.*

Certification: I certify these answers and statements are complete and true to the best of my knowledge and belief. I will inform Aetna of any material changes to the information provided which take place between the time the form is completed and the time coverage becomes effective. I agree that this document shall become a part of my request for group coverage and I acknowledge that I have retained a copy of this document as completed by me.

Acknowledgment: I understand that, to the extent permitted by state law, false statements may result in the denial of claims or in my insurance coverage being void as of its effective date with no benefits payable. I understand that conditions which are disclosed on this form may be subject to all conditions of my employer's Plan including any preexisting condition limitations, fraud provisions and employee actively at work and dependent health condition requirements. My signature indicates that I have reviewed all information and statements on this form for completeness and accuracy.

Authorization: To all physicians and other health professionals, hospitals and other health care institutions, insurers, medical or hospital service and prepaid health plans, and employers: You are authorized to provide Aetna Life Insurance Company (Aetna) information concerning healthcare, advice, treatment or supplies (including those related to mental illness and/or AIDS/ARC/HIV) provided me or any members of my family for whom coverage has been requested. (Minnesota residents are not required to provide information concerning results of AIDS/ARC/HIV tests performed on a criminal offender or a crime victim.) I acknowledge that information obtained from any or all of the above may result in further underwriting investigation. This information will be used for the purpose of determining eligibility for coverage. This authorization will be valid for thirty (30) months from the date signed (Minnesota residents twelve [12] months)**. I acknowledge that I have read the Privacy Notice and Misrepresentation section shown on "Page 2 of 4" of this form and know that I have a right to receive a copy of this authorization upon request.** I agree that a photographic copy of this authorization is as valid as the original.

Employee's or Authorized Person's Signature (*Required at all times*)	Date	Spouse's or Authorized Person's Signature (*Required if spouse coverage is requested.*)	Date